STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151537	A. BUILDING _____ B. WING _____	C 02/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASERACARE HOSPICE	**8460 BEARING DR #300 INDIANAPOLIS, IN 46268**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was a Hospice state complaint investigation survey. Complaint number: IN00102491 - Substantiated: No deficiencies related to the allegation are cited. Survey date: February 13, 2012 Facility number: 008883 Medicaid vendor number: 200141740A Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor Aseracare Hospice is in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.54 Initial and Comprehensive Assessment as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN February 16, 2012	S 000		